NOVA SCOTIA
Community Services

DEPARTMENT OF COMMUNITY SERVICES

Services for Persons with Disabilities

Independent Living Support Policy

Effective: July 28, 2006

Building strong, healthy communities together

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Program Policy:	Services for Persons with Disabilities	
Chapter ___9____:	Independent Living Support Program	
Section ___1____:	Introduction	
Effective: 28/07/06 **Revised:**	**Authorized by:** Marian F. Tyson, Deputy Minister	Page of 1 of 8

1. POLICY STATEMENT

The Independent Living Support (ILS) Program is one program within the continuum of supports and services provided by the Services for Persons with Disabilities (SPD) Program. The ILS Program provides up to 21 hours a week of supports and service to eligible Individuals who are semi-independent and require minimum support in their own apartment or home.

1.2 The intent of the program is to promote independence, self-reliance, and security for eligible Individuals using a collaborative approach to create an integrated and responsive support delivery system which incorporates the strengths of the Individual and community in collaboration with Service Providers.

1.3 The goals of providing up to 21 hours a week of supports and services are to:

- assist Individuals to maintain and build connections and relationships with family, friends and other community members and resources;
- assist Individuals to maximize independence in instrumental activities of daily living such as:
    - maintaining a household
    - laundry
    - shopping and banking
    - preparing meals
    - transportation for community access
    - participating in leisure, volunteer, or work activities
- assist with the promotion and maintenance of health and wellness;
- recognize the potential of Individuals and facilitate opportunities for continuing growth and personal development;
- balance SPD resources and the eligible Individual's expectations in a flexible and responsive manner to meet the assessed unmet needs of eligible Individuals; and
- assist in the prevention of, and / or delay the need for, admission to a staffed residential support option.

1.4 Eligibility for the ILS Program is determined by a functional and financial assessment. Eligible Individuals will have assessed unmet needs which can be addressed by the ILS Program.

1.5 The ILS Program uses the Individual Support Plan approach to promote independence. This approach focuses on the abilities, strengths, identified goals, and assessed unmet needs of those Individuals requiring minimal support services of up to 21 hours per week.

1.6 Individuals in the ILS Program will be eligible to receive funding for assessed unmet needs which may include shelter costs, food, clothing, household items, prescriptions, transportation, a comforts (personal use) allowance, and other approved items included in the SPD policy and procedures. The ILS Program partners with a variety of community supports and outreach resources to address the unmet needs of Individuals and their ability to be supported in the ILS Program. The ILS Program expands the range of sustainable options available in the community and allows individual needs to be met in a more flexible and personal manner.

2. DEFINITIONS

2.1 For the purposes of the ILS Program the following definitions apply.

2.2 Activities of Daily Living
Basic, routine personal care activities that are essential to self-care such as bathing, continence, dressing, grooming, eating, toileting and mobility.

2.3 Applicant
A person who applies for assistance from the Services for Persons with Disabilities Program.

2.4 Approved Budget
A financial plan that details the funds allocated and approved for certain expenditures, and that have received the appropriate supervisory approval.

2.5 Assessment
A process of collecting financial and functional information using a consistent methodology in order to determine if an Applicant / Individual is eligible for assistance from the SPD / ILS Program. Assessment also assists SPD staff in making informed decisions by identifying assessed unmet needs and lays the foundation for identifying appropriate corresponding supports and services.

2.6 Assessed Unmet Needs

Needs identified through an individual functional assessment for which the Individual requires supports and services which are offered through the SPD Program.

2.7 Assistance

Assistance means the provision of money, goods and services to an eligible Individual including residential supports and other supports and services, excluding those available through private insurance and / or any other federal, provincial or community resources

2.8 Budget Deficit

When an Applicant / Individual's total allowable expenses exceed their total chargeable income.

2.9 Care Coordinator

A Department of Community Services / SPD employee responsible for financial and functional assessments, case planning and case management.

2.10 Casework Supervisor / Senior Caseworker

A Department of Community Services employee who, among other duties, is responsible for overseeing the work and decisions made by a Care Coordinator.

2.11 Collaborative Approach

An approach based on a consensus building philosophy which respects and highlights the individual group members' abilities and contributions in order to accomplish a specific goal.

2.12 Continuum of Supports and Services

A mix of program and support options available through SPD for persons with disabilities. This continuum includes in-home, residential and day program supports and services.

2.13 Day Program

Daytime activities that may occur in facility-based settings and / or the community with a view to providing pre-vocational or vocational training, and / or supported employment for persons with disabilities. Some programs may also offer recreational and leisure opportunities.

2.14 Disability

A severe and persistent restriction or impairment that results in an inability to perform an activity within the range considered normal for someone of the same age, gender and culture. It describes a functional limitation (versus a diagnosis) and is ongoing in nature:

I) **Acquired Brain Injury (ABI)** - Damage to the brain that may result in a range of physical, cognitive and behavioural problems, as well as problems which are emotional, social, educational or vocational in nature.

ii) **Developmental Disability** - A disorder characterized by substantial impairment in several key areas of development, i.e. social interaction, communication, behavioural presentation.

iii) **Intellectual Disability** - A significantly lower than average intellectual functioning that is accompanied by limitations in adaptive functioning in at least two skills of life domains, such as: communication, self-care, social / interpersonal, use of community resources, mobility, functional academic skills, behavioural presentation. There are four degrees of severity:

Mild: IQ - 50 to 70
Moderate: IQ - 39 to 55
Severe: IQ - 20 to 40
Profound: IQ - 20 to 25

iv) **Long Term Mental Illness** - A persistent alteration in a person's thinking, feeling or behaviour which creates difficulties in functioning normally, socially or at leisure; examples include schizophrenia, chronic mood disorders.

v) **Physical Disability** - A significant ongoing physical limitation that substantially limits independence and requires ongoing supervision, support, or skills development.

2.15 Eligibility

The determination of whether Applicants / Individuals meet the SPD / ILS Program criteria to receive supports and services.

2.16 Eligible Individual

Refer to definition for Individual.

2.17 Functional Assessment

The determination of the physical, social, recreational, and vocational level of functioning of an Individual that yields a clear and complete profile of an Individual's strengths and needs and assists in identifying assessed unmet needs and goals. The information is collected from a variety of sources including the Individual, direct observation and collateral contacts.

2.18 Independent / Independence

The degree to which Individuals are able to manage their own personal care activities, home and community activities.

2.19 Independent Living Support Program Coordinator

Provincial program coordinator for the ILS Program.

2.20 Individual

A person with a disability who has undergone a financial and functional assessment, is determined to be eligible for the SPD / ILS Program, and receives supports and services offered through the SPD / ILS Program.

2.21 Individual Program Plan (IPP)

An IPP is a detailed plan for accomplishing the Individual's goals and corresponds to the goals identified in the Individual Support Plan.

2.22 Individual Support Plan (ISP)

A document that integrates and documents all supports and services the Individual may receive. The ISP identifies the assessed unmet needs, related goals, and the objectives required for meeting the person's preferences, choices, and desired outcomes. The Individual Support Plan is developed by the Care Coordinator, with the full participation of the Individual, their family, and / or person acting on their behalf, service providers, and others as appropriate.

2.23 Instrumental Activities of Daily Living (IADL)

More complex functions than basic self-care activities of daily living. IADLs include using the telephone, making and keeping appointments, handling money, budgeting, managing medication, shopping, using transportation, moving about in the community, maintaining a household, preparing meals, laundry, housekeeping, working, and participating in leisure and recreational activities.

2.24 Person acting on their behalf

Refers to:

(I) any person who acts on the Individual's behalf when the Individual has given written permission;

(ii) the Individual's legal guardian; or

(iii) a person with power of attorney for the Individual.

2.25 Personal Support Network

A network made up of individuals such as doctor(s), therapist(s), members of the community, family, and friends that are involved or support the Individual with different parts of their life.

2.26 Re-assessment / Review

A second or subsequent assessment of an Individual and / or their circumstances. Re-assessments identify an Individual's strengths and needs. Re-assessments are typically performed annually and / or in response to changes in circumstances and / or in order to identify changes in needs and / or resources.

2.27 Semi-independent

An Individual who requires a minimum level of support and skills development in preparation for independence and / or enhancement of their independence.

2.28 Service Provider

An organization or person that provides support services under a Service Provider Agreement to Individuals in the ILS Program.

2.29 Service Provider Agreement

An agreement that is signed between the Department of Community Services and a Service Provider that outlines the responsibilities, expectations, and financial arrangements for supports and services provided to Individuals in the ILS Program.

2.30 Services for Persons with Disabilities (SDP) Policy

Community Supports for Adults Policy Manual, its amendments and additions, and any successor policies and procedures.

2.31 Services for Persons with Disabilities (SPD) Specialist

A Department of Community Services SPD employee responsible for regional delivery of SPD Programs.

2.32 Support and Services

Providing help to Individuals with routine personal care activities and more complex functions. In the Independent Living Support Program this help is often provided by encouraging, teaching and facilitating an Individual's independence to the greatest extent possible, particularly as it relates to instrumental activities of daily living.

2.33 Transfer

Transfers between SPD Program options.

2.34 Transition

Discharge from a SPD Program.

3. POLICY OBJECTIVE

The objective of this policy is to provide SPD staff, applicants, Service Providers, eligible Individuals and members of their personal support network when appropriate, with an introduction to the ILS Program and policies.

4. APPLICATION

4.1 For the purposes of the ILS Program the following application statement applies to all the policies contained within this chapter.

4.2 All the policies contained within this Chapter apply to all SPD staff, service providers, eligible Individuals or persons acting on their behalf when appropriate, involved in the ILS Program.

5. ACCOUNTABILITY

5.1 For the purposes of the ILS Program the following accountability statements apply to all the policies contained within this chapter.

5.2 All SPD staff, Service Providers, applicants, eligible Individuals or persons acting on their behalf when appropriate, are responsible for complying with this policy and general SPD policy.

5.3 Casework Supervisors / Senior Caseworkers and District Managers are responsible for the fair and consistent application of the policies, related guidelines, and procedures as a part of case management supervision duties and responsibilities.

5.4 The Regional Administrator, SPD Specialist, and ILS Program Coordinator are responsible for ensuring the policy is effective in enabling SPD Staff to deliver the ILS Program in an efficient and cost-effective manner.

5.5 The SPD Division, in consultation with the Regional Management team, is responsible for ensuring that SPD Staff have access to appropriate training.

6. MONITORING

6.1 For the purposes of the ILS Program the following monitoring statements apply to all the policies contained within this chapter.

6.2 The SPD Division is responsible for ensuring that an effective ongoing review and periodic evaluation is in place to determine that the ILS Program is meeting its objectives.

6.3 The Deputy Minister, Assistant Deputy Minister, and Senior Management are responsible for monitoring the effectiveness and the consistent application of this policy.

Program Policy:	Services for Persons with Disabilities	
Chapter ___9_____:	Independent Living Support Program	
Section ___2____:	Eligibility for ILS Program	
Effective: 28/07/06 **Revised:**	**Authorized by:** Marian F. Tyson, Deputy Minister	Page 1 of 2

1. POLICY STATEMENT

To identify Applicant who are eligible and whose support needs can be accommodated through the Independent Living Support Program.

2. DEFINITIONS

Refer to Chapter 9, Section 1: Introduction 2.1 - 2.34.

3. POLICY OBJECTIVE

To define the eligibility criteria for the ILS Program for Individuals with disabilities.

4. APPLICATION

Refer to Chapter 9, Section 1: Introduction 4.1 - 4.2

5. POLICY DIRECTIVES

5.1 Eligibility for ILS Program

5.1.1 An applicant must be eligible for the SPD Program in order to be eligible for the ILS Program.

5.1.2 To be eligible for the ILS Program the assessment process must identify that an applicant meets the following criteria:

- they require no more than 21 hours of support a week;
- they are under the age of 65;
- they are able to access crisis support independently and are able to use an emergency response system;
- they are able to manage medication with minimal support and guidance;
- they are able to participate in decisions about their activities and needs, and are able to communicate these needs / preferences to others; and
- they are willing to participate in the Individual Support Planning process.

5.2 Ineligibility for ILS Program

5.2.1 An applicant is ineligible for the ILS Program when the assessment process identifies unmet needs for supports and services that cannot be provided within ILS Program resources and / or within 21 hours a week. These circumstances include, but are not limited to:

- the applicant has safety and risk issues which cannot be accommodated and supported within the ILS Program;
- the applicant is over the age of 65;
- there are medication management issues that present concerns for the applicant's health and well-being that cannot be reliably and safely supported;
- appropriate professional and outreach supports identified as being required cannot be provided due to logistics, cost or availability;
- the applicant requires long-term or ongoing overnight support;
- the applicant is unable to access crisis support independently and / or is unable to use an emergency response system; and
- they are ineligible for the SPD program.

6. ACCOUNTABILITY

Refer to Chapter 9, Section 1: Introduction 5.1 - 5.5.

7. MONITORING

Refer to Chapter 9, Section 1: Introduction 6.1 - 6.3.

Program Policy:	Services for Persons with Disabilities	
Chapter ___9 ___:	Independent Living Support Program	
Section ___3____:	ILS Program Coordination	
Effective: 28/07/06 **Revised:**	**Authorized by:** Marian F. Tyson, Deputy Minister	Page 1 of 6

1. POLICY STATEMENT

To establish an integrated and responsive support delivery system for the ILS Program that encourages the use of collaboration, which builds on the strengths of the Individual, community, and Service Providers.

2. DEFINITIONS

Refer to Chapter 9, Section 1: Introduction 2.1 - 2.34.

3 POLICY OBJECTIVE

To establish a standardized approach to identify and coordinate the supports and services available through the ILS Program to address the assessed unmet needs of eligible Individuals.

4. APPLICATION

Refer to Chapter 9, Section 1: Introduction 4.1 - 4.2.

5. POLICY DIRECTIVES

5.1 Overview of ILS Program to Applicants / Individuals

5.1.1 All eligible Applicants / Individuals and their families when appropriate, shall be provided with an overview to the ILS Program, policies, and procedures by a Care Coordinator.

5.2 Individual Support Plan Development

5.2.1 Each eligible applicant shall have an Individual Support Plan (ISP) developed based on the information obtained through the assessment process. The ISP shall identify the Individual's assessed unmet needs and Individual's goals in the following areas which may include, but is not limited to:

- level of assistance and support with Instrumental Activities of Daily Living (IADLs) and Activities of Daily Living (ADL);
- health maintenance and promotion;
- medication management;
- family and / or personal network involvement;
- emergency arrangements;
- community participation;
- professional supports;
- vocational, social, and leisure activities;
- hours of support;
- budgeting and financial management;
- approved items of special requirement.

5.2.2 The Care Coordinator shall use a collaborative approach throughout the Individual Support Plan process. The process involves the Individual, their family, and / or others from their personal support network, as identified by the Individual.

5.2.3 The Individual Support Plan process an assists in identifying the Individual's goals, strengths, and abilities and their assessed unmet needs. It also identifies the corresponding supports and services required to achieve the prioritized goals; and is implemented in collaboration with the appropriate Service Provider.

5.2.4 The Individual Support Plan will be signed by all participants.

5.3 Determinating Hours of Support

5.3.1 Hours of support may range from 1-21 hours per week and is determined on an individual basis by the Care Coordinator after consultation with the Individual and the Service Provider.

5.4 ISP Approval and Hours of Support

5.4.1 The ISP and the recommended hours of support shall be approved by the Casework Supervisor / Senior Caseworker.

5.5 Ongoing Reviews and Support

5.5.1 The Care Coordinator shall review an Individual's circumstances using a comprehensive assessment process, to determine ongoing eligibility for the ILS / SPD Program. The review shall involve updating the Individual Support Plan when circumstances warrant. These reviews shall be conducted and documented at the following intervals:

- after 3 months of initial ILS Program admission;
- annually; or
- more often when circumstances warrant.

5.5.2 The review shall involve the Service Provider, the Individual, their family, and significant others such as medical and clinical support teams, adult service centre and day program personnel, as appropriate.

5.5.3 Care Coordinators are responsible for ensuring that written documentation reflects completed reviews and changes, as appropriate.

5.6 Transfer and Transition

5.6.1 When an Individual's circumstances have been reviewed and it is determined that the Individual requires a change in their supports which cannot be provided in the ILS Program, the Individual shall be transferred to an alternate residential setting which meets those needs.

5.6.2 When an Individual requires a transfer to an alternate residential setting, SPD Staff shall provide support planning for these transfers. Transfer plans shall be discussed and developed in cooperation with the Service Provider(s), the Individual, family, and their personal support network when appropriate, and will follow SPD policy and procedures.

5.6.3 When an Individual has been assessed and determined ineligible for ILS and SPD Programs, SPD Staff shall follow SPD policy and procedures regarding planning and transitions.

6. POLICY GUIDELINES

6.1 Shared Living Circumstances

6.1.1 Individuals in the ILS Program may choose to share their accommodations with another Individual in the program.

6.1.2 In these circumstances each Individual shall have their own Individual Support Plan and hours of support, however, support hours may be shared when it is appropriate.

6.1.3 Expenses associated with accommodations will be shared and documented in the Individual's budgets.

6.1.4 Individuals who wish to share their accommodation with a person outside the ILS Program shall have the prior approval of the Casework Supervisor / Senior Caseworker, who shall consult with the SPD Specialist.

6.2 Short-Term / Emergency Circumstances

6.2.1 When an Individual requires additional supports and services beyond the maximum 21 hours a week, for short term or emergency circumstances, Care Coordinators may request approval for additional support on a short-term basis, not to exceed 4 weeks, as outlined below in sections 6.2.2 - 6.2.6.

6.2.2 Short-term or emergency circumstances include periods when an Individual's participation in the ILS Program is compromised and assessed unmet needs increase due to:

- a short-term deterioration in mental and / or physical health;
- a traumatic / stressful event, i.e. death in family;
- disruption or reduction in natural or community supports; or
- increased safety risks that can be managed with additional hours of support.

6.2.3 When short-term or emergency supports and services are assessed as necessary, Care Coordinators shall submit the following written documentation for approval:

- the reason for additional support and service hours;
- the support alternatives explored and rejected;
- the benefits of the additional supports and / or services;
- re-assessment plans to monitor the effectiveness of the additional supports and services;
- expected end date for additional hours of support; and
- the costs associated with the additional support needs.

6.2.4 Approval may be granted for additional support hours up to an additional 20 hours per week, for a maximum total of 41 hours per week, for up to 4 weeks.

6.2.5 Approval may be granted at the following levels after consultation with the SPD Specialist, who shall provide notification to ILS Program Coordinator:

- up to and including an additional 10 hours per week may be approved by the District Manager;
- up to and including an additional 20 hours per week may be approved by the Regional Administrator; and

- for approval of additional hours over 20 hours per week refer to 6.3 Exceptional Circumstances.

6.2.6 The additional hours of support shall be reviewed by the Care Coordinator after four weeks to assess the ongoing need and effectiveness of the additional supports. If it is determined that the additional hours are required on an ongoing or long-term basis, the Individual shall be re-assessed to identify unmet needs and to determine a more appropriate SPD program option.

6.3 Exceptional Circumstances

6.3.1 All requests for approval of hours of support that exceed the additional 20 hours per week, for a total of 41 hours per week, shall require documentation as outlined in 6.2.3 of this section and requires Senior Management approval. All requests for exceptional circumstances are assessed and determined on an individual basis.

6.3.2 Approval for hours of support over the additional 20 hours per week may be considered:

- when the additional support is required on a short-term basis, 4 weeks or less; or
- when no suitable vacancy exists, and supports are required on an interim basis until a more appropriate placement option for the Individual is secured.

6.3.3 The requests shall be prepared by the Care Coordinator and forwarded to the Casework Supervisor / Senior Caseworker for consultation with the SPD Specialist and authorization of the Regional Administrator.

6.3.4 Requests shall be forwarded by the Regional Administrator to the Director of SPD for recommendation and referral to the Executive Director and forwarded to the Deputy Minister for final approval.

6.4 Documenting Additional Hours of Support

6.4.1 Any instance of additional hours of support over 21 hours per week shall also be documented by the Care Coordinator. The information gathered and documented will be considered in the re-assessment of the Individual Support Plan and the evaluation of the supports and services offered by the ILS Program.

7. ACCOUNTABILITY

Refer to Chapter 9, Section 1: Introduction 5.1 - 5.5.

8. MONITORING

Refer to Chapter 9, Section 1: Introduction 6.1 - 6.3.

9. APPENDICES

Individual Support Plan template

Program Policy:	Services for Persons with Disabilities	
Chapter ___9____:	Independent Living Support Program	
Section ___4____:	Financial Assessment for ILS Program	
Effective: 28/07/06 Revised:	Authorized by: Marian F. Tyson, Deputy Minister	Page 1 of 3

1. POLICY STATEMENT

To establish a standardized approach for determining financial eligibility and assistance for applicants to the ILS Program.

2. DEFINITIONS

Refer to Chapter 9, Section 1: Introduction 2.1 - 2.34.

3. POLICY OBJECTIVE

To ensure financial resources are used efficiently and effectively to provide appropriate supports and services to eligible applicants.

4. APPLICATION

Refer to Chapter 9, Section 1: Introduction 4.1 - 4.2.

5. POLICY DIRECTIVES

5.1 Assistance for Eligible Individuals

5.1.1 The Care Coordinator shall determine an applicants financial eligibility for the ILS Program by conducting a financial assessment in accordance with SPD policy and procedures. As assessments are done for each Individual the provision of assistance to Individuals will not be identical in all cases.

5.1.2 In conducting a financial assessment the Care Coordinator shall:

- follow SPD policy regarding financial eligibility and budget development;
- ensure assistance does not exceed the rates and allowances provided by SPD policy;
- develop a budget for the Individual using the assistance provided for by

SPD policy and this Policy, and in the event one contradicts the other this Policy shall be followed.

5.1.3 Individuals in the ILS Program are eligible to receive funding to purchase hours of support. In addition, Individuals are also eligible to receive funding for assessed unmet needs which may include shelter costs, food, clothing, household items, prescriptions, transportation, a comforts (personal use) allowance, and other approved items included in SPD policy and procedures.

5.1.4 When the applicant has been determined eligible for the ILS Program, and if the ILS Program funding is not available in the fiscal year in which service is requested, the applicant's name shall be placed on a wait list, upon their request.

5.2 Management / Trusteeship of Individual's Funds

5.2.1 All Individuals participating in the ILS Program are encouraged and entitled to participate in the management of their finances to the greatest extent of their ability.

5.2.2 Care Coordinators will ensure the level and type of financial support is documented through the Individual Support Plan process.

5.2.3 When a Service Provider is required to provide financial management support to Individuals the Service Provider shall:

- receive funds for the benefit of the Individual for the purposes of administering expenses such as rent, utilities, food, clothing and other miscellaneous items on their behalf, in accordance with SPD and this Policy and the Individual's support plan, as required;
- establish an account with a financial institution and utilize amounts received for the Individual for those items that are specifically approved for the Individual;
- prepare a monthly account reconciliation and provide appropriate receipts, which shall be available to the Department upon request.

5.3 Start-up Costs

5.3.1 Start-up costs are available as a one time expenditure to eligible Individuals when they have insufficient furnishings or household items to contribute to the establishment of an apartment or home.

5.3.2 Start-up costs require the approval of the Care Coordinator or Casework Supervisor / Senior Caseworker, depending on the amount of funding being requested.

5.3.3 The Care Coordinator, in consultation with the Casework Supervisor / Senior Caseworker, may approve funding to replace, or help with replacement, of furnishings or household items when the existing item owned by the Individual is no longer serviceable.

5.4 Hospitalization or Absent from Home

5.4.1 The Care Coordinator shall ensure there is no disruption in monthly funding when an Individual is absent from home for the purposes of vacation, visiting family or hospitalization for less than 30 days, as per SPD policy.

5.4.2 The Care Coordinator shall seek approval from the Casework Supervisor / Senior Caseworker to continue to provide assistance under the ILS Program, as required, during extended absences beyond 30 days, when there is confirmation that the Individual is returning to their home and a return date is known.

6. ACCOUNTABILITY

Refer to Chapter 9, Section 1: Introduction 5.1 - 5.5.

7. MONITORING

Refer to Chapter 9, Section 1: Introduction 6.1 - 6.3.

8. APPENDICES

Service Provider Agreement template
Individual Support Plan template
ILS Budget Sheet template
Monthly Invoice template
Furnishings and Household Items Rate Guidelines

Program Policy:	Services for Persons with Disabilities	
Chapter ___9_____:	Independent Living Support Program	
Section ___5____:	Service Provider Agreement	
Effective: 28/07/06 **Revised:**	**Authorized by:** Marian F. Tyson, Deputy Minister	Page 1 of 2

1. POLICY STATEMENT

A Service Provider Agreement (the Agreement) will strengthen accountability and quality of the delivery of support services to eligible Individuals.

2. DEFINITIONS

Refer to Chapter 9, Section 1: Introduction 2.1 - 2.34.

3. POLICY OBJECTIVE

To ensure that Service Provider services are delivered through a standardized written agreement.

4. APPLICATION

Refer to Chapter 9, Section 1: Introduction 4.1.

5. POLICY DIRECTIVES

5.1 Service Provider Agreement

5.1.1 All Service Providers are required to sign a service agreement. The Agreement outlines the provision and delivery of support services by the Service Provider, program expectations, roles and responsibilities, conditions for termination of the Agreement, and frequency of reviews and updates. The funding arrangements shall be outlined in an attached Schedule.

5.1.2 The Agreement shall also be signed by departmental staff authorized to act on behalf of the Minister.

5.1.3 Any modifications to the Agreement shall require the approval and signature of the SPD Director.

6. ACCOUNTABILITY

Refer to Chapter 9, Section 1: Introduction 5.1 - 5.5.

7. MONITORING

Refer to Chapter 9, Section 1: Introduction 6.1 - 6.3.

8. APPENDICES

Service Provider Agreement template

Program Policy:	Services for Persons with Disabilities	
Chapter ___9___:	Independent Living Support Program	
Section ___6____:	Service Provider Funding and Responsibilities	
Effective: 28/07/06 **Revised:**	**Authorized by:** Marian F. Tyson, Deputy Minister	Page 1 of 4

1. POLICY STATEMENT

The SPD Division recognizes that the supports and services offered by the ILS Program are best offered in collaboration with natural supports, community resources, and Service Providers.

2. DEFINITIONS

Refer to Chapter 9, Section 1: Introduction 2.1 - 2.34.

3. POLICY OBJECTIVE

To establish a standardized approach and process for the provision, coordination, and monitoring of supports and services delivered by a Service Provider.

4. APPLICATION

Refer to Chapter 9, Section 1: Introduction 4.1.

5. POLICY DIRECTIVES

5.1 Service Provider Responsibilities

5.1.1 Service Providers that provide support to Individuals in the ILS Program shall:

- ensure that their staff involved in the provision of supports and services have a criminal record check, including the vulnerable sector search, are bondable, and meet the required training and qualifications as outlined by the Department's Core Competency Standards for Community Residential and Vocational Services in Nova Scotia;
- agree to participate in the Individual Support Planning process and to develop an Individual Program Plan that complements the Individual Support Plan;

- sign an Agreement; and
- provide the supports and services to Individuals as identified by the Care Coordinator and approved by the Casework Supervisor / Senior Caseworker, as included in the Individual Support Plan and budget and in accordance with the provisions of the Agreement and this Policy.

5.2 Service Provider Funding

5.2.1 Funding is provided to a Service Provider based upon the hours of support required by the Individual as determined by their assessed unmet needs and goals as identified through the Individual Support Plan process.

5.2.2 The costs associated with delivering up to 21 hours a week of support, at a rate as approved by the Department and attached as a schedule to the Agreement, shall be documented on the Individual's ILS Budget Sheet.

5.2.3 Funding is payable in advance to the Service Provider, with the exception of travel expenditures, on or about the beginning of each month upon receipt of a Departmentally approved monthly invoice that details the approved expenditures.

5.2.4 The Service Provider shall submit monthly invoices to the Care Coordinator for payment. The invoices shall contain:

- an itemized statement of approved and actual expenditures with proof in the form of receipts or other documentation, as required;
- a detailed record of all income of the Individual; and
- a mileage log detailing dates, locations and kilometres travelled for each Individual.

Payment of all approved expenditures and transportation and mileage costs shall require Care Coordinator approval and signature before payment.

5.3 Management of ILS Participant Funds

5.3.1 All Individuals participating in the ILS Program are encouraged and entitled to participate in the management of their finances to the greatest extent of their ability.

5.3.2 Care Coordinators will ensure the level and type of financial support is documented in the Individual Support Plan.

5.3.3 When a Service Provider is required to provide financial management support to an Individual the Service Provider shall maintain written documentation detailing how funds are administered on behalf of the Individual. Also Refer to Chapter 9, Section 4: Financial Assessment for ILS Program: 5.2 -5.2.3.

5.4 Individual Support Plan Development

5.4.1 The Service Provider shall participate in the development and reviews of the Individual Support Plan, led by the Care Coordinator, for each of the Individuals they support, and provide a detailed Individual Program Plan that complements the Individual Support Plan.

5.5 Reporting and Documentation

5.5.1 Service Providers shall maintain current and accurate records for Individuals participating in the ILS Program to ensure the safety and continuity of supports and services.

5.5.2 Ongoing and regular communication between the Service Provider and the Care Coordinator is required. This communication will be both verbal and in writing and will ensure the Care Coordinator is kept up to date on all circumstances that may affect the Individual's support and service needs.

5.5.3 Service Providers shall provide monthly and quarterly reports to the Care Coordinator which outline the Individual's status, progress, and / or any concerns:

- monthly reports are provided in an agreed upon manner as outlined in the Individual Program Plan;
- written quarterly reports shall be provided on a monthly basis for the first three months of a new ILS arrangement, and thereafter shall be forwarded to the Care Coordinator on a quarterly basis.

The Care Coordinator will review and follow up with the Service Provider and ILS Participant, as required.

5.5.4 Service Providers shall inform the Care Coordinator of any critical, serious or unusual incidents that involve Individuals participating in the ILS Program. Service Providers must complete a Notification of Incident form, when appropriate.

5.5.5 Service Providers are required to notify the Care Coordinator of all changes that:

- impact on the support needs of the Individual and the Individual Support Plan; and

- affect the Service Provider's ability and capacity to provide support as outlined in the Service Provider Agreement.

5.5.6 The Care Coordinator shall document any changes in the Individual's file and respond as required.

5.5.7 The Service Provider shall ensure that all information and records pertaining to Individuals supported through the ILS Program are maintained and stored in a secure and confidential manner, and provide access to these records when requested by the Department and / or the Individual.

6. ACCOUNTABILITY

Refer to Chapter 9, Section 1: Introduction 5.1 - 5.5.

7. MONITORING

Refer to Chapter 9, Section 1: Introduction 7.1 - 7.3.

8. APPENDICES

Service Provider Agreement template
ILS Budget Sheet template
Individual Support Plan template
Core Competencies Standards for Community Residential and Vocational Services
Monthly invoice template
Notification of Incident form